THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.224b Quality assurance assessment fee; use; circumstances; definitions.

Sec. 224b. (1) The department of community health shall assess a quality assurance assessment fee as follows:

(a) On each health maintenance organization that has a medicaid managed care contract awarded by the state and administered by the department of community health, a quality assurance assessment fee that equals 6% of non-medicare premiums collected by that health maintenance organization.

(b) On each medicaid managed care organization that is a specialty prepaid health plan under section 109f of the social welfare act, 1939 PA 280, MCL 400.109f, and that has a medicaid managed care contract awarded by the state and administered by the department of community health, a quality assurance assessment fee that equals 6% of non-medicare capitation payments collected by that medicaid managed care organization.

(2) The quality assurance assessment fee collected under subsection (1) and all federal matching funds attributed to that fee shall be used for the following purposes and under the following specific circumstances:

(a) The quality assurance assessment fee shall be implemented on May 10, 2002 for health maintenance organizations described in subsection (1)(a) and on August 1, 2005 for medicaid managed care organizations described in subsection (1)(b).

(b) The quality assurance assessment fee shall be assessed on the non-medicare premiums collected by each health maintenance organization described in subsection (1)(a) based on the health maintenance organization's most recent statement filed with the commissioner pursuant to sections 438 and 438a. Except as otherwise provided, the quality assurance assessment fee shall be payable on a quarterly basis with the first payment due 90 days after the date the fee is assessed. If a health maintenance organization does not have non-medicare premium revenue listed in a filing under section 438 or 438a, the assessment shall be based on an estimate by the department of community health of the health maintenance organization's non-medicare premiums for the quarter and shall be payable upon receipt.

(c) The quality assurance assessment fee shall be assessed on the non-medicare capitation payments collected by each medicaid managed care organization described in subsection (1)(b) based on the medicaid managed care organization's most recent financial status report filed with the department of community health. Except as otherwise provided, the quality assurance assessment fee shall be payable on a quarterly basis with the first payment due 90 days after the date the fee is assessed.

(d) The quality assurance assessment fee shall only be assessed on an organization described in subsection (1)(a) or (b) that has in effect a medicaid managed care contract awarded by the state and administered by the department of community health at the time of the assessment.

(e) Beginning October 1, 2008, the quality assurance assessment fee shall no longer be assessed or collected.

(f) The department of community health shall implement this section in a manner that complies with federal requirements. If the department of community health is unable to comply with the federal requirements for federal matching funds under this section for organizations described in subsection (1)(a) or is unable to use the fiscal year 2001-2002 level of support for federal matching dollars other than for a change in covered benefits or covered population required under the state's medicaid contract with health maintenance organizations, the quality assurance assessment fee under subsection (1)(a) shall no longer be assessed or collected.

(g) If the department of community health is unable to comply with the federal requirements for federal matching funds under this section for organizations described in subsection (1)(b) or is unable to use the centers for medicare and medicaid services approved fiscal year 2004-2005 level of support for federal matching dollars other than for a change in covered benefits or covered population required under the state's medicaid contract with the managed care organization, the quality assurance assessment fee under subsection (1)(b) shall no longer be assessed or collected.

(h) If an organization fails to pay the quality assurance assessment fee required under subsection (1), the department of community health may assess the organization a penalty of 5% of the assessment for each month that the assessment and penalty are not paid up to a maximum of 50% of the assessment. The department of community health may also refer for collection to the department of treasury past due amounts consistent with section 13 of 1941 PA 122, MCL 205.13.

(i) The medicaid health maintenance organization quality assurance assessment fund is established as a separate fund in the state treasury. The designated medicaid managed care organization quality assurance assessment fund is established as a separate fund in the state treasury. The department of community health

shall deposit the revenue raised through the quality assurance assessment fee under subsection (1)(a) with the state treasurer for deposit in the medicaid health maintenance organization quality assurance assessment fund. The department of community health shall deposit the revenue raised through the quality assurance assessment fee under subsection (1)(b) with the state treasurer for deposit in the designated medicaid managed care organization quality assurance assessment fund.

(j) In all fiscal years governed by this section, medicaid reimbursement rates shall not be reduced below the medicaid payment rates in effect on April 1, 2002 for organizations described in subsection (1)(a) or below the medicaid payment rates in effect on July 1, 2005 for organizations described in subsection (1)(b) as a direct result of the quality assurance assessment fee assessed under this section. This subdivision does not apply to a change in medicaid reimbursement rates caused by a change in covered benefits or change in covered populations required under the state's medicaid contract with organizations described in subsection (1)(a) or (b).

(3) As used in this section:

(a) "Medicaid" means title XIX of the social security act, 42 USC 1396 to 1396v.

(b) "Medicare" means title XVIII of the social security act, 42 USC 1395 to 1395hhh.

History: Add. 2002, Act 304, Imd. Eff. May 10, 2002;—Am. 2002, Act 621, Imd. Eff. Dec. 23, 2002;—Am. 2005, Act 83, Imd. Eff. July 19, 2005;—Am. 2007, Act 88, Imd. Eff. Sept. 30, 2007;—Am. 2008, Act 283, Imd. Eff. Sept. 29, 2008.

Popular name: Act 218